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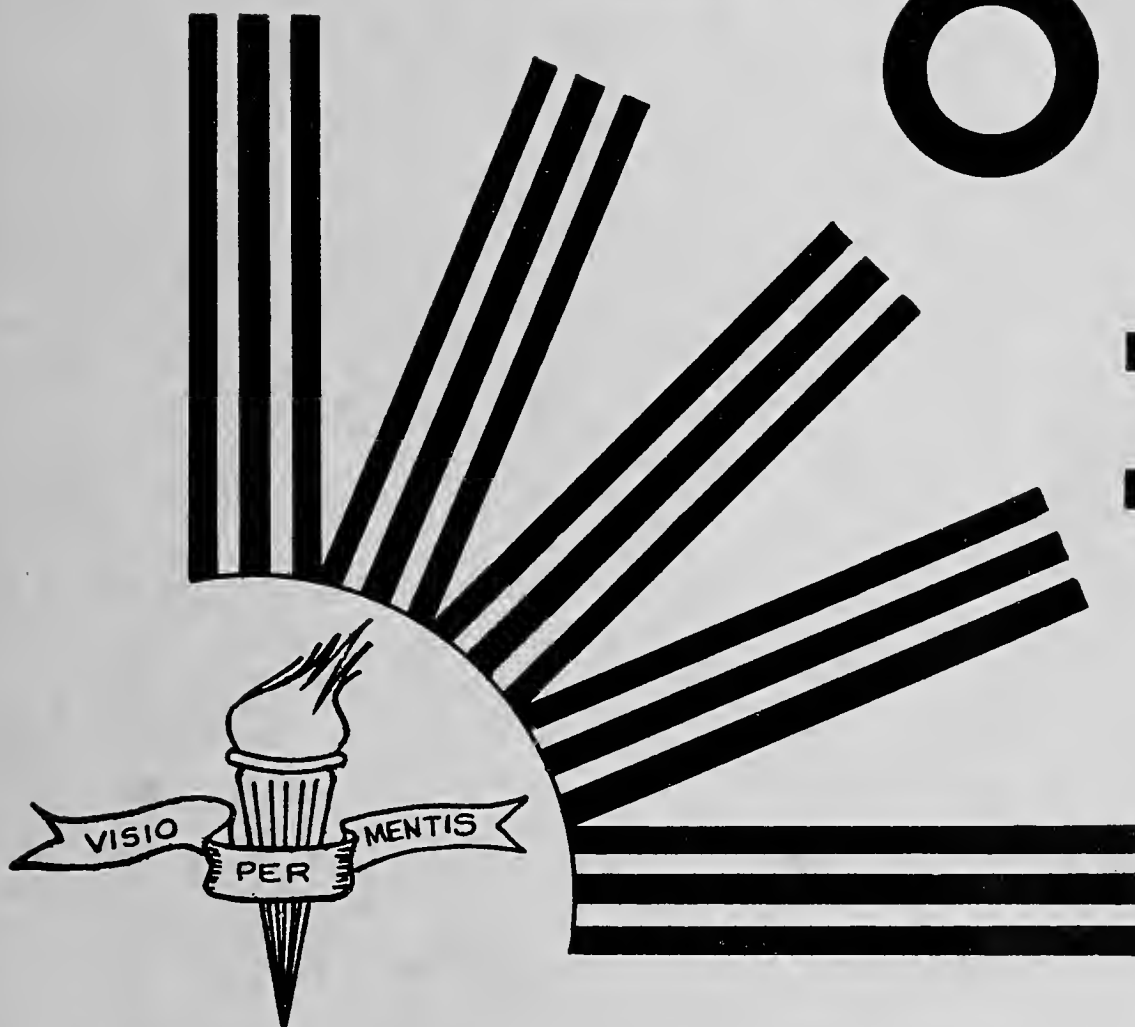
NOVEMBER, 1954

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From The Associate Editor,

One of the many problems faced by the optometry graduate every year is that pertaining to his status in military service. The problem is a serious one and should be especially contemplated upon by the non-service veteran who will most probably find himself eventually serving his country as a member of some branch of the Armed Services.

Lack of sufficient knowledge pertaining to the Military Optometry situation up to now has, I believe, been the prime factor hindering the progress which should be made.

This article is written with the belief that enlightenment is the door to the sound and decisive action necessary for the promulgation of changes in Military Optometry today.

At the present time, there are three medical service corps and three surgeons general, one each for the Army, Navy, and Air Force. Each department has its own rules and regulations but although this seems to present a great deal of non-uniformity, the three departments are now in the process of restricting all refractions to be made by commissioned officers.

Since the end of hostilities in Korea, there has been a sizeable reduction of armed forces personnel with a subsequent reduction of available commissions in all departments of the service.

This past year, however, the Air Force has begun to increase its number of commissioned personnel, resulting in a corresponding increase in the number of available vacancies for optometrists.

I believe that it is worth elaborating, at this point, upon the policy which both the Army and Air Force adhere to rather closely regarding these vacancies. These openings for commissioned optometrists are first offered to enlisted optometrists on active duty. However, the acceptance of the commission by the already enlisted optometrist would automatically necessitate his acceptance of additional active duty which is required if the commission is accepted. Although there is no doubt a sufficient number of qualified enlisted optometrists, most of these men decide to complete the rest of their stay in the service in their present status rather than to accept the commission which has approximately two years of additional service associated with it.

The remaining vacancies are often filled by optometrists connected with Army, Air Force, and Naval Reserve Units, the latter consisting of almost three hundred commissioned optometrists.

Finally, whatever vacancies remain are then

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Omega Epsilon Phi

By John Lamont and Thomas Couch

They told us that our short story would hold a reader's interest if it began by mentioning either Deity, royalty or sex. And so it begins . . .

"My God," cried the Duchess, "get your hands off my knee!" Now that you are totally engrossed we can continue.

As you know, or as you will learn la-a-ater, the annual O.E.P. Smoker at the Hotel Brunswick has come and gone although for many (whose nomens we will not divulge), the effects may be still lingering on.

Ah, what a night—our only hope is that the fish swimming in the area of Moon Island enjoyed the party as well as did Bill Hissey and Don Dixon. However, while sipping our ale (ginger) and stumbling on the slippery suede stoppers (say that fast—yeh, well we bet you couldn't do it that night) we picked up the following comments:

Wally Flynn—"Why did I have to bring my car?"

Bob Graham—"But Wally . . ."

Bob Brouillette—"What a revoltin' development—no more bottle openers."

Lou Legris—"Ah-r-r-r-r-r-r."

Bob Graham—"But Wally . . ."

Al Lamont—"Why can't we have one of these every night?"

Dr. Cline—"Take out a piece of paper, Eastman."

Ted Kaknes—"Very good."

Bob Graham—"But, But Wally . . ."

Dr. Kuhn—"Very good entertainment!"

Paul Taylor—"Yes sir, Doctor, yes sir!"

Earl Lupien—"Is that my buddy, Tass—'down there'?"

Bob Graham—"But Wally . . ."

Bob Milot—"Who slipped me the mickey?"

Afentakis—"Pete, now play The Blue Danbue."

Pete Eudenbach—"One more drink and I'll float down it."

Bob Shulman—"Where are the goils?"

Ed Richards—"Don't breathe on me, Charley."

Bob Graham—"But Wally . . ."

John Gould—"Hey, Art, Tom, Elmer, Ken, bring me one."

John Good—(later on)—". . . Bail me out will yuh?"

Bob Graham—"But Wally . . . oh shucks, he passed out. If only he listened. He didn't

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Ocular Dominance
Mitchell Kuhn, O. D.
Assistant Professor in Theoretic
and Corrective Optometry

The dominant eye, master eye, directing eye, sighting eye, leading eye, controlling eye, orientating eye, and fixing eye are terms that have been used synonymously.

Eye dominance may be defined as the faculty which one of the eyes commonly exercises of dominating, or leading, the other, both in fixation and in attentive or perceptive function. The dominant eye seems to assume the predominant role of looking directly at an object, while the other eye turns sufficiently to produce the convergence necessary for single binocular vision. The dominant eye also generally controls the amount of accommodation used.

Generally, each individual has a leading eye. When the vision in the two eyes is unequal from some pathological or refractive reason, or when strabismus exists, the better eye usually attains a position of marked supremacy, but when the two are approximately equal in visual acuity, there may be little evidence of dominance. Nevertheless, with suitably applied tests, the habit of ocular dominance is found to be almost universally demonstrable in some degree.

Many tests for ocular dominance have been proposed from time to time. These may be described in three categories.

1. COMPARATIVE FUNCTIONAL ABILITY:

When looking into a stereoscope, the image that is seen better and maintained longer usually belongs to the dominant eye.

When trying to fuse two colors, one for the right eye and the other for the left in a stereoscope, the blending does not usually represent a physical mixture of the component colors. Rather, the more common effect is to see one color belonging to the dominant eye and to suppress to a moderate extent the color seen by the nondominant eye.

The phenomenon of retinal rivalry may indicate which eye is dominant. The master eye is taken to be that whose image predominates in the fluctuations which ensue.

The strength and persistence of after-images may also indicate which eye is dominant.

The dominance of one eye over the other also explains why the two images of an object seen double do not have the same psychological value,

even when they are equidistant from their respective foveas. In making the experiment of fixing upon a far object and seeing a near object double, most observers can readily detect that one of the two images of the near object is more vivid than the other. The image that is more vivid is the one seen with the dominant eye. It is surmised that this image is more substantial because the observer is unconsciously fixing his attention more upon it than upon that seen by the other eye.

The main criticism of all these tests is that they are entirely subjective, added to which is the fact that a higher efficiency—especially when the difference is slight—does not indicate with certainty that the eye in question is habitually dominant.

2. TESTS ASSOCIATED WITH MUSCULAR BALANCE OR MOVEMENTS:

These tests are equally uncertain.

In strabismus, simple inspection is usually sufficient to determine which is the fixing eye.

When doing the cover test in cases of heterophoria, if the eyes do not deviate equally when they are alternately covered, the eye which deviates the least when occluded may be taken to be the dominant eye.

When using dissociating prisms before each eye in a phoria test, the patient usually sees one object as stationary and one as moving. The stationary object belongs to the dominant eye. This test also is open to objection because the dominant eye indicated may depend upon whether a full correction, partial correction, or no correction is in place.

When testing the near point of convergence, one eye will usually give up fixation and deviate outward when the eyes cannot maintain convergence any longer, leaving the dominant eye still fixating the test object.

3. UNILATERAL SIGHTING TESTS:

These tests undoubtedly provide the best criterion.

Hole-in-the-card test (Percival-Dolman test): A card of arbitrary size, say 5" x 8", with a hole in the center about 1 or 2 inches in diameter is held with both hands at arm's length. The patient is instructed to fixate a small, distant object, such

as a spot of light. While both eyes are open, he is told to raise the card until he can see the fixation object through the aperture. Once the patient can see the object through the opening, he should not move his head or the card. Occlude one of the patient's eyes. If he still sees the object of regard, the non-occluded eye is dominant. If the patient must move the card or states that the object of regard has disappeared, the occluded eye is dominant. This test seems to be one of the most reliable ones.

An aperture can be created by palming. The principle is the same as for the hole-in-the-card test.

The dominant eye can be determined by asking the patient to look into an ordinary microscope or telescope, or any other monocular device. The eye chosen is usually the master eye.

Reversed cone: A cone similar to a megaphone may be used, with the wide end near the face. The cone is held in both hands and is brought up in front of the eyes in such a manner as to permit the patient to see the small, distant object of regard through the cone. By placing an occluder card between the cone and face, the dominant eye can be ascertained.

The pointing test is quite commonly used in practice. The patient is asked to point to a small, distant object with his finger. The object and the finger will be in alignment with either the right or the left eye, as can be ascertained by alternately occluding the eyes. The eye which is in line with the finger and the object is the dominant eye. Physiologic diplopia, which causes the finger to be seen double, may cause confusion in this test. This test is open to objection as the results may depend in some cases on which hand is used.

BROCK'S BINOCULUS TEST:

In single binocular vision, the cyclopean eye is a theoretical construct, located between the two eyes in the median plane of the head, perhaps slightly displaced toward the dominant eye. In monolateral amblyopia, this cyclopean eye may be shifted more laterally, while in strabismus—especially if complicated with amblyopia—the cyclopean eye may shift and occupy the same place as the dominant eye.

Procedure: The fixation target is a bright light (about 100 watts) at a distance of ten to twenty feet from the patient. It is best to have the room dimly illuminated. A black piece of cardboard,

about 6" x 8" with a central hole ($\frac{3}{4}$ " in diameter) is given to the patient. He is instructed to hold the card lengthwise in both hands and directed vertically, while his arms are held straight and close to his sides. He is instructed to fixate the light and to bring the card straight up in front of him with the arms fully outstretched, until he sees the light through the hole. Because the card is between the patient and the light, a spot of light can be seen moving up the patient's body as the card is being raised. The examiner watches the movement of this spot.

In single binocular vision, the spot of light follows the midline of the body toward the centrally located cyclopean eye. When this relationship is attained, the individual cannot see the light with either eye, and automatically will move the card laterally to the dominant eye. Quite often the lateral movement will begin at the neck, chin, or nose; and in these cases, it follows an oblique line to the eye.

When the light comes up on the lateral side of the body directly to either eye, lack of a binocular pattern, as well as dominance of that eye, are indicated. If the light comes up in a position intermediate to the midline and the lateral side, it indicates a strong shift of the cyclopean eye, but that some degree of the binocular pattern is still in evidence.

Eye dominance may also be revealed by the fact that the patient holds print closer to the straight ahead position of the dominant eye. This may produce an aniseikonia or be the result of one which existed before correction.

Any of the above tests should be repeated several times, and it is advisable to use more than one method.

The significance of ocular dominance is by no means fully understood. In the problem of right and left-handedness, one hand alone is used for many tasks and the preponderance of one is natural. In the case of the eyes, however, the case is different, for binocular vision is a unitary perception. Thus, if a person looks at a landscape so that parts of the field are obscured from either eye, it is quite impossible for him to tell which parts of the field of vision are seen by either eye unless he shuts one or the other. Nevertheless, when a choice is forced between the two eyes, there is ample statistical evidence to show that the great majority of individuals (about 98%) choose one consistently (Gould, 1908; Sheard, 1923; Mills, 1925; Shastid, 1926; Pascal, 1926; Miles

1928-30).

There is a tendency for agreement between the dominant eye, dominant hand, and dominant foot. This is perhaps due to the greater activity of the cerebral hemisphere which governs the favored side,—the right hemisphere in the case of left-handed persons and the left hemisphere in the case of right-handed persons. However, eye dominance may be influenced by such things as anisometropia, functional conditions, congenital amblyopia, congenital defects of the media of one eye, disease of one eye, a discrepancy in the visual acuity of the two eyes for any reason, etc. Also, there may have been an alteration of hand dominance at some time. In adults, the right eye is the dominant eye in about 64% of cases and the left eye in 34%. In right-handed persons, 33% show left ocular dominance, and left-handed people are approximately equally divided between right and left dominance. Adults and children show similar proportions, and these are maintained in races as widely different as Chinese and Americans.

Lavery believes that since handedness is determined by early training, the major problem is one of the sidedness of the individual from a standpoint of cerebral control, and that the dominant eye is a more accurate indication of the cerebral sidedness of the person than is the matter of right or left handedness.

Little or no indication is available as to when the preference for one eye first shows itself in development, or whether the habit is established as a result of environmental conditions or tendencies of motor co-ordination, but all the evidence points to the fact that dominance is innate and can only be reversed with difficulty, if at all. In monolateral strabismus, one eye is the fixing eye; however, in alternating strabismus, either eye becomes the fixing eye. In anti-metropia, the person will prefer the hyperopic eye for distance and the myopic eye for near. However, in the case of binocular vision without such abnormalities, dominance is usually an irreversible unilateral phenomenon. In adult life, special tasks involving the use of one eye mainly, such as prolonged uniocular microscopic observations, do not determine an ocular dominance and do not alter a preference already established.

In cases of non-association of eyedness and handedness, some investigators have found that use of a red filter (No. 215 Fiberloid) worn over the dominant eye for a few weeks is sometimes successful in reversing the eye dominance, thus

shifting the master eye to the side of the dominant hand and resulting in greater comfort for the patient. Use of total occlusion, however, does not seem to be very effective in altering eye dominance.

From a practical consideration of coordination, opposite handedness and eyedness causes less efficiency than coincident dominance.

Many believe that changing the handedness of children causes psychological implications, most of which are concerned with personality difficulties.

The synchronized use of the eye and hand is mainly a process which takes place through the autonomic portion of the central nervous system. The less obstructions in the path of this cycle, then the smoother the completion of the act and the less the amount of nervous energy expended for its accomplishment. This seems to make it evident that the ideal relationship is attained when the hand and eye dominance are coincident.

In many cases of stuttering, the trouble seems to lie in non-association of eyedness and handedness.

Patients often complain about one eye in particular. This eye is usually the dominant one. Be particularly careful to get the most exact correction for the dominant eye as possible. If possible, slightly better vision should be given to the dominant eye. If an additional .25D reverses the preference rather than equalizes it, it is advisable to permit the dominant eye to retain the better vision.

Some individuals are left-handed and right-eyed, but write with their right hand, having been taught to do so in school. They do not have as much difficulty as some of the other types. This type of patient is the one which the teacher is able to change over to right-handedness without too much difficulty and it is interesting to realize what a part the dominant eye played in the case without its being realized.

Those children who are left-handed and left-eyed should be allowed to develop their left-handed tendencies as it is doubtful if one would be successful in changing over both the handedness and the eyedness. It is much better to encourage the use of the left hand for writing. In order that this may be done to the best advantage of the patient, he should hold the pen differently from the right-handed person. The pen or pencil should be held backhand with the point toward the body. This will avoid creating a shadow and also will not

crowd the arm and hand too much against the body.

Knowledge of the dominant eye would be valuable to the school teacher in just such cases as these. The dominant eye rather than the dominant hand should be the deciding factor as to whether a child should be taught to use the right hand in preference to the left when he has left-handed tendencies. For years the emphasis has been on the hand without regard for the eye. It is also this type of patient who rebels at being forced to use the right hand for writing.

Cases of adult patients of this type have been reported who had learned the use of the right hand and who did work which necessitated the synchronized use of the eye and hand. Most of them were quite nervous and by the simple expedient of encouraging their return to the use of the left hand their symptoms have been alleviated.

A relatively small proportion of people is ambidextrous. They fall into two classes. There are some who have no dominant eye. When making the test for eye dominance, they hold the hole in the card in such a position that both eyes get a glimpse of the target at an angle. There is another class, however, that change their dominance ac-

cording to which hand is being used. For example, if the right hand is used for some task then the right eye is dominant; and likewise, if the left hand is used then the left eye is dominant.

Many believe that due to the physiological importance of the dominant eye, certain precautions must be taken to preserve intact the status of a natural tendency. The basis of these suggestions is that in making phoria tests, and also in prescribing prisms for constant wear, the dominant eye should be undisturbed. The lateral phoria may vary according to whether the measuring prism is before the dominant or non-dominant eye. It is preferable to place the dissociating element before the non-dominant eye. If unequal prisms are prescribed, the stronger prism should be placed before the non-dominant eye if possible.

It would seem, therefore, that we should include in our routine examination a dominant eye test and also the question as to which hand is dominant and whether it has always been dominant.

Sufficient evidence of scientific value is still lacking in this field.

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offered to civilian optometrists.

Although these methods of filling vacancies for commissions in optometry are no doubt fair to the individuals involved, they still leave a great deal to be desired.

There are now approximately 255 commissioned optometrists on active duty in the Army, Navy, and Air Force.

The Military Advisory Committee of the A.O.A. is doing everything it possibly can, under the circumstances, to better the optometrist's position in the service. There is of course a limit to what can be accomplished by this A.O.A. Department of National Affairs, primarily because existing congressional laws relating to Military Optometry limit the military from enacting the important changes which the A.O.A. believes are now necessary under our present post-war conditions.

The important advances which Military Optometry has made since the start of World War II have not been in proportion to the even greater advances made by Civilian Optometry during the same period. There is a definite need for added improvement.

Emphasis, however, should be heavily placed upon the fact that the lack of commissioned optometrist vacancies is really due to the inadequate regulations imposed upon the branches of the services. The lack of vacancies is NOT due to the fact that there is no NEED for proper and adequate visual care in the services. This fact must be strongly emphasized.

Adequate visual care is definitely lacking. The patient load on the Army's Eye Clinics, is very heavy and considering the Army's stress on good vision, it is not understandable why adequately trained personnel are not utilized more than they now are. There are three optometrists screening 1200 men per week and average forty to sixty refractions per day, at one particular army post. Another post utilizes as many as 45 dentists for every optometrist. Is the proper visual care administered in these cases? To this question you will very quickly answer in the negative and no doubt logically ask, "Why hasn't something been done about this? Why is this situation permitted to remain unchanged?"

Again, I must reiterate that the solution to this problem does not lie solely with the military since they are bound by law to a great extent to administer the rules and regulations, laid down by Congress, pertaining to the administration of each branch of the service.

It should therefore be clear what OUR plan of action must be. Congress should be made aware of the existing injustices present in Military Optometry today. We should each contact our Senators and Representatives, either personally or by letter, to make them cognizant of the enormous potentialities in the field of visual care possessed by Military as well as Civilian Optometrists.

Contacts should also be made with the members of the House Committee on Military Affairs and the Senate Committee on Armed Services to urge for, 1) an increased optometric quota, and 2) an assurance that direct commissions be granted to Civilian Optometrists.

If this important project be successfully supported by each of the twelve optometry colleges in the country, and by every single student in these institutions, as well as by every State Optometric Association, A.O.A., and other small optometric groups, nothing but good can come from the impetus created by this large scale movement.

It is optometry's duty to repeatedly make Congress aware, again and again, that optometry can provide the necessary visual care which is so noticeably lacking in each branch of the service.

As members of the youngest Health Profession, are we going to let the problems of Military Optometry remain as a thorn in our sides, or are we ready and willing to reach up and grasp the rights and privileges which are rightfully ours?

O.E. Phi — (*Continued*)

bring his car and didn't have to take it easy.

Judging from the comments, we have this to say to those who did not attend—"you fools you."

Several rumm—we mean students have pledged to the confines of O.E.P. We wish to welcome these pledgees and sincerely hope that they will feel free to enter our fair abode and shoot the breeze with the brothers about studies, girls, the instructors, girls, exams, girls, problems, and . . . ha.

The fraternity room as you will know by this late date has been redecorated by Tom Ferrara and cohorts. Another outstanding accomplishment by another outstanding accomplished man. Egad, Couch, you CAN write (?) after all.

Mrs. Tom Ferrara with her hubby Tom, an outstanding accomplished man among outstanding accomplished men, put on a luncheon for the fraternity that will be an epicure long remembered.

We leave you with the thought that we all should remember that each man may have his wife, but only the iceman has his pick.

SPORTALK WITH COUCH

The Basketball season is here again at M.C.O. This year its star-studded squad should really give the college fans something to cheer about. Lacking in reserves last season, M.C.O. had a split won lost record. Now with the depth and support gained by six new entrants to the team, coach Kuhn should have more than enough talent to show that basketball is here to stay at M.C.O.

The BASKETBALL SQUAD (at a glance)

Bob Brouillette—6' 3"

Center, who has broken all scoring records at the college averaging 35.4 per game in 23 games.

Dave Borstein—5' 11"

Fast, hard-driving forward.

Wally Flynn—5' 11"

Vitality plus. His rivulent team spirit inspires all.

Al Greaves—5' 11"

Adept ball-handler. Playmaker of the team.

John Good—5' 11"

Fast, versatile player with stratagem.

Paul Taylor—6' 3"

Versatile. At one time or another, has played every position. Veteran rebounder.

CANDIDATES

Phil Hughes—6'

Hard driving forward with good body and arm movement in faking an opponent out of position.

Sumner Kagan—5' 10"

Plays hard and tough and jumps as if there were springs in his feet.

Paul Manning—5' 4"

A Lilliputian whose celerity will be a valuable asset.

Earl Lupien—5' 9"

A player of solidity that will strengthen the team.

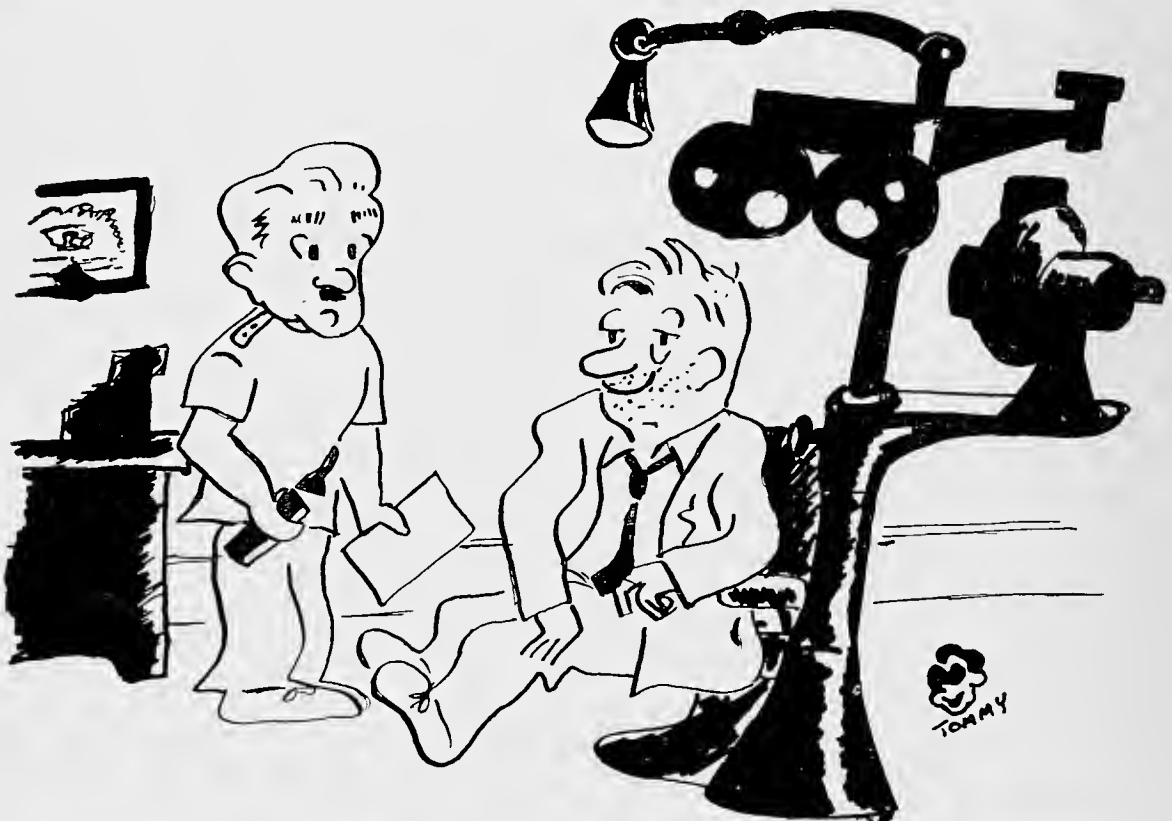
Bob Milot—6' 1"

A team player who gives his utmost both on the court and off.

Dana McCurdy—6' 3"

Height and a scrapper at all times.

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Doctor—I can't find the cause of your diplopia. Offhand, I'd say it's due to drinking.

Patient (understandingly) — Perhaps I better come back, Doc, when you're sober.

Syntonics

By L. L. McCormick, Hutchinson, Kansas

PART II

It is also noteworthy to point out that autonomic centers located in the lower part of the diencephalon at the base of the brain have the following functions: (a) Thyroid gland stimulation, (b) Lacrimal gland stimulation, (c) Sugar metabolism regulation, (d) Adrenal gland stimulation, (e) Salivary gland stimulation and Kidney regulation, (f) Sweat Gland Stimulation, (g) Vasomotor control, (h) Fat metabolism regulation, (i) Possible uterus control, (j) Possible bladder control, (k) Temperature regulation, (l) Sebaceous gland stimulation, (m) Protein metabolism regulation, (n) Pupil regulation.

Dr. Carl W. Lang has been well aware of the importance of pupil size and regulation as is pointed out in his book, "Sight Development" (6) "The pupil of the binocular deficient is definitely larger than normal. Quite frequently this enlarged pupil seems to enlarge again and become larger than it was at first. This symptom is so prevalent that its presence should definitely cause the Optometrist to suspect a binocular problem. In Syntonics this system not only represents a binocular problem but also a definite imbalance in the Autonomic Nervous System.

In Dr. Spitler's book, "The Syntonic Principle" (4) he goes into much more detail and touches on many areas which will not be mentioned in this paper.

Perhaps you would be interested in Dr. Spitler's theory of one of the causes of Amblyopia. He believes Amblyopia to be due to excessive "Synoptic-delay." By that he means that the accumulated potential difference in the axones to a synapse is not great enough to excite the dendrite to the next cell, and believes that perhaps the theory of Pasque, that of condensor action of the Synapse, adequately accounts for a large group of cases of Amblyopia. Clinically, it has been found that the use of those light frequencies which decrease ionization in the retina at times effective in so permitting such a build up of potential difference as to cause an impulse to cross a synapse much in the same manner that once an impulse jumps a synapse to the dendrite of the next cell a path should become permanently open and would forever after be a conductor of impulses received thereat. Clinically, this is exactly what is found. The following

conclusions are the direct outgrowth of the factual and clinical evidence presented herein and represent Dr. Spitler's considered judgment in the evaluation of the data.

1. There exists a closely predictable relationship between light frequency incident into the eyes and their responses.

2. There exists a relationship between light frequencies and the rate of growth of cells and tissues, and their rate of cell division.

3. There exists a relationship between the light in the environment and the physical development of the individual.

4. There exists a relationship between light frequency in the eyes and the mass body potentials.

5. There exists a relationship between the light frequency environment and the development of the biotype, modifying the hereditary tendency.

6. There exists a relationship between light and light frequency and the action currents leaving the eye toward the brain, these action currents being both qualitatively and quantitatively altered.

7. There exists a relationship between light frequency incident into the eye and the functioning power of the pituitary gland.

8. There exists a relationship between the reproductive cycle and the light frequency environment, probably a quantitative one in respect to the number of individuals of any species.

9. There exists a relationship between the light frequency environment and the dynamic tension present between the two divisions of the autonomic nervous system.

10. There exists a relationship between the light frequency environment and the secretion of hormones by all of the coacting as well as antagonistic endocrine glands with the pituitary as the "master gland."

11. There exists a relationship which is largely predictable between light frequency environment and the restoration of health following departures from the normal which are still within physiologic limits, particularly those departures which may be directly influenced by the automatic or the endocrines toward health.

12. There exists a relationship between light frequency into the eye and the degree of nerve cell irritability thus modifying reflexes.

13. There exists a relationship between light frequency into the eye and bodily health.

14. There exists a relationship between nerve impulses from the eye, due to incident light frequency and the state of tension in the autonomic nervous system.

15. There exists a relationship between light frequency into the eye and either its vitamin A content, or the degree of its adaptation.

16. There exists a relationship between light frequency into the eye and the perception of pain.

17. There exists a relationship between light frequency into the eye and the relative responses of both striped and smooth muscles.

18. Syntony of the autonomic may be produced by light frequency into the eye.

19. The ability to continue to live depends upon syntony of the autonomic in both acute and chronic illnesses, and this attainment of syntony may be aided by light frequency into the eye.

From these foregoing conclusions just read you can begin to realize with just what a powerful medium we are working. Furthermore, you can readily see and understand why there have been some wild and fantastic claims made. It is not the purpose in Syntonic Optometry to go off the deep end and start treating heart trouble, high blood pressure, frost bite, lumbago or what have you, but to deal with ocular anomalies. It might be of interest to you to read this set of statistics handled by the Syntonic principle.

The total number of individuals syntonized 3067 of which 2791 responded, which is a 90.7%.

	No.	Resp.	%
Phoria, eso-exo, hyper	295	232	78.65
Low blur, break or recovery findings	246	205	83.63
Asthenopia with discomfort	683	634	92.8
Tropias, including eso-exo- and hyper	103	77	74.85
Amblyopia-undetermined cause	242	185	76.00
Progressive myopia, progress stopped or minus power reduced	68	46	67.65
Headaches of ocular origin	725	629	89.51
Latent hyperopia	64	60	93.74
Color field contraction-red 47; green 60; blue 65	172	153	88.89
Associated and supportive functions of vision	275	184	66.9
Ocular Reflex or referred pains	144	115	79.79
Opacities, including senile cortical, diabetic, occupations,			

congenital	425	268	63.59
Optometric departures from normal not classified above ..	158	112	70.88
The average number of syntonizations was 7.79 per patient.			

It would be called to your attention that syntonics is only one principle dealing with different light frequencies. Color therapy is mentioned by Dr. William Luftig who is a graduate of the University of Berlin. On page 45 in his book entitled "The Natural Treatment of Eye Disease" (7) It says: Sufficient experience of color - or photo therapy shows that its merits are so great that this kind of radiation - therapy must be regarded as an important therapeutic measure. Much greater use ought to be made of it. Unfortunately, in medical circles little is known about its therapeutic results and to my knowledge, there are no books which deal with the subject of color therapy in eye diseases.

It was noticed in a brochure from a Canadian school that they too are obtaining excellent results with some form of color therapy. (8) It should be pointed out also that in the Vol. 35, No. 3, 1951 issue of the Electronic Medical Digest, page 28, are listed 32 references for those interested in Color Therapy. (9) Some of you too are probably familiar with Chromorthoptics which is another principle. Dr. Scown who spoke before our assembly in Wichita in April, 1949, mentioned in one of his lectures that he had been successful in dissolving some cataracts with a yellowish green frequency.

The college of Syntonic Optometry is composed of some outstanding men, men who use O. E. P. or Analytical Optometry. Among its membership you will find State Board Members, officers of State Associations, PhD's and many others who are interested in the patient's health and welfare. These men get together at least once a year and present papers of interesting cases and then the papers are discussed. Some of these papers are in the form of a thesis done on a research problem, others are brief but interesting.

Here are two excerpts taken from two different papers. As practitioners of one of the healing arts, we receive as patients and consultants many who are simply in need of good refraction and or visual training. On the other hand, many of these people do not have their problems, symptoms, and complaints adequately taken care of by or with a lens prescription or training, for even if these are tried. we have learned that complaints still persist. It

behooves us as members of a particular branch of the healing arts, who have been consulted for answers to their problems, to do what we can to find what their complaint is, and then try to do something about it, refer the patient to members of other branches of the healing arts for their aid in diagnosis and help where possible, or help the patient ourselves if it is within our power to do so, or refer the patient to another member of our profession, who we feel is capable of handling the case satisfactorily.

The use of the Syntonic Principle in the practice of the specialist in the care of vision, makes possible the proper care of the nature or the normalization of vision in adult life (visual geriatries) without the Syntonic Principle of Practice very little could be done for this ever increasing large group of people, other than the "patch-up" work of the past.

Here are some courses suggested for an educational program. A course in Neuro-anatomy, or Neuro Physiology, Light Physics, Vision and Color Vision, Endocrinology and Nutrition.

The qualifications for becoming a Syntonist are the same as for a fellow in the American Academy of Optometry; he also must be ethical and practice in a professional manner and have his application signed by two Syntonists.

In conclusion the author would like to leave this question with you. After reading this paper, does it sound like "quackery" or does it sound as if those who are dealing in Syntonics are really interested in helping their patients? The author feels that the practice of Syntonic Optometry is a wonderful adjunct to the already recognized and established visual training procedures. Even though wonderful and fantastic things can be accomplished with Syntonics it is not necessary to practice in this manner. If only amblyopic, myopic, and discomfort cases are handled successfully then Syntonics has served its purpose and deserves its place in the Visual Training Field.

—KANSAS OPTOMETRIST

Sportalk continued

With these men coach Kuhn has returning Tom Couch, manager and John Janes, trainer. John and Paul Taylor joined the Matrimonial Team since last season and now have to keep trim for more than one team.

Conjointly with the returning varsity and new candidates coach Kuhn's Maroon and White show promise to have more puiſſance in the squad than ever previously displayed.

FIRST YEAR ARTICLE

by Sumner Kagan and Pete Paresky

At this time the freshman class at Massachusetts College of Optometry, two months of age, is just beginning to feel a part of the college. It is gradually becoming familiar with the school, the professors, the profession, and the hundreds of minor but important facts and experiences which all come with time and which the upper classmen have already assimilated painlessly. As time goes on, individual faces and personalities of upper classmen and of members of our class become more familiar both to us and to the college as a whole. The feeling of belonging that we are quite rapidly and unconsciously acquiring only goes along with our participation in college activities. These activities include not only attending classes but also extra-curricular college functions such as fraternity smokers, basketball games, and also spontaneous discussions with upperclassmen.

In spite of the short time that we have been in the school, we have nevertheless gleaned innumerable impressions. Some have been of a more serious nature concerning optometry, its practices and problems, which were so excellently illustrated to us by Dean Green at both fraternity smokers. Other impressions on the lighter side were left both by our current professors and by such men as Dr. Namias and Dr. Cabitt whose repertoires seem to have only been tapped at fraternity smokers and from whom we are quite eager to hear more. Concerning our own professors, we have been deeply touched by the patience and genuine desire to teach of men such as Dr. Wright and Mr. Arnold.

After nearly a month of life without "Rocky" we can hardly distinguish any more between an astragalus and a calcaneum. We feel, however, that we have sacrificed a rather nondescript knowledge of teeth and bones for something of far greater importance to the well-being of our country, namely the extraction of a vital metal ore from the surface of the earth (*viva la Cadillac*).

Tears come to our eyes as phrases such as "Students" and "That's m'boy" seem to leap out of the walls of our zoology lecture room. However, we feel that our beloved "Rock", whom we truly miss has been adequately replaced by Mr. Tyzkowski (there).

Our most able Dr. March has demonstrated not only by his teaching but also by his personality exactly what we should strive for in attaining the

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ideal professional attitude, viz. openmindedness, an intense desire to learn, and the finesse and pride of a gentleman.

We would like to take this opportunity to assure Dr. Wekstein that his gems of wisdom are being absorbed in spite of the handicap of meeting at such an ungodly hour.

Now for some vital statistics about our class. It is comprised of 17 embryo optometrists. Of these men, two are married, seven are veterans, and four hold bachelor's degrees from various colleges and universities. The average age of our class is 22 years. Among us are representatives of the states of Massachusetts, Rhode Island, New Hampshire, Maine, and New Jersey.

Recently an election of class officers was held. The following were elected to office: John McCauley—President; Louis Luisi—Vice-president; Frank Pepicelli—Treasurer; Emory Clark—Secretary; Peter Piscia—two-year representative to the Student Council; and Philip Hughes—one-year representative.

* * * *

The Boston Society of Optometrists and the Massachusetts College of Optometry jointly announced as a public service to the community, a series of free lectures on topics dealing with problems of sight and a general understanding of the human eye.

The first lecture was held Sunday afternoon, November 21st, at the college. The speaker was Dr. Ralph H. Green, Dean of the College. His topic was "The Human Eye—The How and Why of Vision." His talk was amply illustrated with a question period following.

Among the future lectures are listed such topics as:

1. Your Children's Eyes.
2. Age and the Eyes.
3. Near Sightedness, Far Sightedness, Astigmatism.
4. Your Eyes and Your Job.
5. Prevention of Blindness.
6. The Problem of Crossed Eyes.

Further reports on this program of public relations will be acknowledged as a tribute to the efforts of the Boston Society of Optometrists to further the profession of Optometry.



SOFT-LITE LENSES

**lighten the labor of
extra visual activity**

Many eyes are sensitive to such visual conditions as higher brightness contrasts, fluorescent lighting, TV viewing, excessive near-point work. Natural flesh tone Soft-Lite absorptive lenses provide comfort without discernably altering color values. You perform additional service for every patient by including a subjective light sensitivity test with the B&L Trial Case Accessory. Ask the B&L Branch, or the Independent distributor of B&L products in your community, to demonstrate it.

